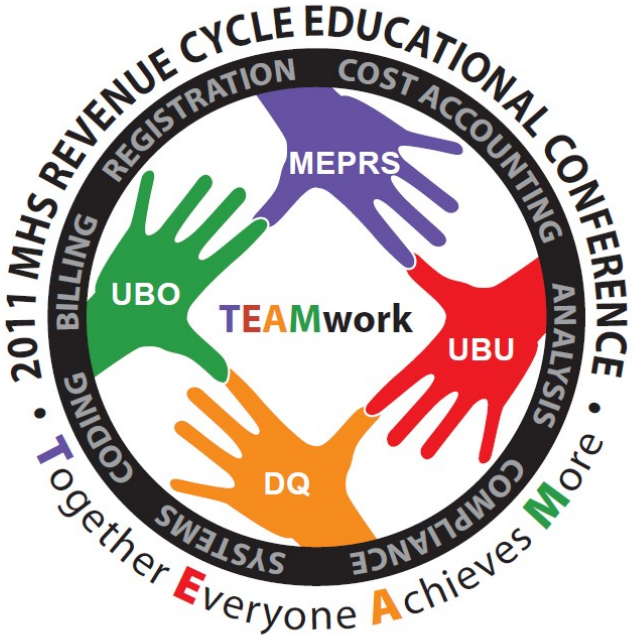

Title: **Documentation Matters: Why is Clinical Documentation Important?**

Session: **Wednesday, 16 March 11, 0800-0850**

Objectives

- Explain the importance of clinical documentation
- Describe how clinical documentation became critical with the implementation of the Medicare Prospective Payment System and other cost-reduction initiatives
- Provide principles of documentation
- Describe the contents of the medical record
- Identify Documentation Improvement best practices
- Discuss how documentation impacts quality of care, financial planning, healthcare outcomes and appropriate reimbursement
- Provide documentation examples

Documentation Matters

“If it was not documented, it was not done”

Documentation Matters

Why is clinical documentation important?

- Documentation is critical for patient c
- Serves as a legal document
- Quality Reviews
- Validates the patient care provided
- Good documented medical records reduce the re-work of claims processing
- Compliance with CMS, Tricare and other payers regulations and guidelines
- Impacts coding, billing and reimbursement

Background

- Medicare is largest payer of health insurance for about 46 million beneficiaries
- Majority of Medicare spending is Fee-for-Service (FFS) with hospitals and physician services representing the largest share of spending
- With program having this magnitude of expenditures payment errors can occur which can impact the treasuries and taxpayers
- In an effort to decrease the cost of healthcare, CMS began developing initiatives to offset spending but still focusing on quality of care

Background

Hospital Reimbursement

- 1965 - Medicare reimbursed hospitals based on actual charges for treatment provided
  - Increased reimbursement costs
  - Emphasis was on codes being on bill submitted

- 1983 - Medicare implemented the Inpatient Prospective Payment System (IPPS)
  - Payment method based on fixed rates
  - Development of a Diagnostic Related Groups (DRG)
  - Thought to be cost-effective
  - Coding becomes more engaged

Background

Hospital Reimbursement

- 2007 - CMS introduced Medicare Severity Diagnosis Related Groups (MS-DRGs)
  - Better reflect patient's severity of illness
  - Risk of mortality
  - More emphasis on documentation and coding

- CMS then required reporting of Present on Admission indicators in 2008
  - Identify conditions present or
  - Acquired during the patient's stay
  - Adjustment in reimbursement

Background

Hospital Reimbursement

- CMS anticipated facilities would focus on documentation improvement
  - In order to capture severity of illness
  - Increase their reimbursement

- 2011 – Documentation and Coding Adjustment (DCA) was introduced by CMS
  - Determined that increase in reimbursement was due to better documentation
  - Not due to the treatment of sicker patients
  - Negative adjustment in reimbursement rate 5.8% by 2012

Background

- Implementation of PPS and MS-DRGs and introduction of Physician's Pay-for-Performance and Value-Based Purchasing initiatives identified the need for complete documentation
  - Recovery Audit Contractor
  - Medicare Integrity Contractor
- Hospitals and physicians focused on improving their clinical documentation to keep abreast with the new CMS changes

Documentation Matters

Impact of clinical documentation

Patient

- Quality of care provided
- Continuity of care
- Non-payment by Insurance for illegible condition or treatment

Physician

- Demonstrates accountability
- Performance Management
- Reduced or denied payment

Facility

- Coding and Billing
- Supporting documentation for treatment and services rendered
- Appropriate reimbursement

Documentation Matters

- CMS (Medicare) requires that ALL medical conditions evaluated and treated as well as a patient's health history, past & present illness, and outcomes are documented in the medical record

Documentation Matters

Principles of Documentation

- Complete and legible
- All entries should be dated and authenticated by physician/provider
- Documentation of each patient encounter
  - Date & Reason for the encounter
  - Appropriate H&P and prior diagnostic test results
  - Review of lab, x-ray data and other ancillary services
  - Assessment and Plan of Care (discharge plan)
- Codes reported should reflect the documentation

Documentation Matters

Principles of Documentation

- Past & present diagnoses

  should be accessible to physician (treating or consulting)
- Reason for and results of x-ray, labs should be documented
- Relevant health risk factors should be identified
- Documentation should support
  - Diagnosis and describe the patient's treatment

Documentation Matters

Principles of Documentation

- Patient's progress notes should include
  - Change in diagnosis
  - Response to treatment
  - Change in treatment
  - Patient non-compliance

- Discharge Plan/Plan of Care should include
  - Treatments and medications
  - Frequency of medication & dosage
  - Any Referrals
  - Discharge instructions for follow-up

Documentation Matters

In a nut-shell

Clinical Documentation in the Medical Record should be

- Complete
- Legible
- Timely
- Concise
- Clear
- Patient Centered
- Accurate

Documentation Matters

Medical Record – Source Document

- Communication tool between providers
- Ability of physicians and other health care professionals to evaluate & plan the patient's care
- Accurately and timely claims review & reimbursement
- Utilization Review & Quality of care evaluation
- Collection of data and Resource Management
- Used for research and education

Documentation Matters

Content of Medical Record

- Discharge Summary
- History & Physical
- Progress Notes
- Nursing Notes
- Operative Reports, if any
- Medication Record
- Flow Charts
- Lab & Radiology Reports
- Orders

Best Practices for Improving Documentation

- Advent of regulatory changes driven by CMS requiring improved documentation
- Requirement of an Electronic Medical Record
  - Forms/Template development
  - Using the same wording throughout
  - Copy and Paste
  - Copy Forward
- Hospitals need to prepare for changes in future payment methodologies
- Complete and concise documentation leads to correct coding and correct coding leads to appropriate reimbursement

Best Practices for Improving Documentation

What can you do?

- Conduct and assessment of your current department
  - Evaluate staffing needs
  - Review current medical record processes
- Identify areas that need improvement
- Benchmark Performance
- Review coding and compliance policies and procedures
- Start a documentation improvem program or make improvements to your current one

Documentation Improvement

Key Implementation Factors

- Organizational Support
- Leadership Support
- Resources
- Professional Development
- Available Medical Record and Coding Staff
- Support Staff
  - Example: Case Managers

Documentation Improvement

Developing a Clinical Documentation Program

- Develop a Plan
  - Inpatient & Outpatient
- Identify Resources
  - Personnel
  - Systems availability
- Set Goals
- Buy-in
  - Organization and Leadership
  - Medical Staff
  - Benefits
- Measure Performance
- Market and promote program

Documentation Improvement

Assessment

- Conduct a comprehensive focus review
  - Inpatient
  - Outpatient
- Identify areas that need improvem
  - Percentage of Coding errors
  - CC/MCC capture rate
  - Diagnosis/Procedure omission
  - Accuracy of DRG assignment
  - Percentage of Coding Errors due to documentation
- Determine direction based on outcomes

Documentation Improvement

Goals

- Improve documentation to ensure good quality of care
- Optimal reimbursement
- Correct Coding and DRG Assignment
- Improve patient outcomes
- Patient satisfaction
- Continuous coding education/training
- Physician education/training
- Capturing severity of illness
- Complications and co-morbidities

Documentation Improvement

Buy-in

- Entire MTF needs to commit to the documentation improvement program
  - Otherwise, it will not work
- Communicate with leadership
- Schedule weekly meetings to promote program
  - Present benefits
  - Metrics variance
  - Include example of results
- Explain role of concurrent coding and clinical documentation specialists
  - Composition of clinical documentation improvement (CDI) team

Documentation Improvement

Team Composition

- Model #1 – HIM
  - Coding professionals that have clinical experience, for example
    - Nurses
    - RHITs
    - Clinical Coding Specialists

- Model #2 – Case Management
  - Based on the rationale that the case manager is a “healthcare team member” who has clinical knowledge
- Model #3 – Quality Outcomes
  - Clinical documentation reviewed from a “quality perspective” with primary focus on outcomes

Documentation Improvement

Benefits of CDI Team

- Intermediary between physicians and coders
- Review record from a clinical perspective
- Identify gaps in documentation
- Bridge the gaps in communication between
  - Providers
  - Missing test results
  - Physician orders
- Advocate concurrent and retrospective queries

Documentation Improvement

Benefits of a CDI Team

- Concurrent queries
  - Decrease Backlog
  - Minimize retrospective queries
- Verbal communication with the physicians leads to improved
  - Specificity in the Documentation
  - Quality Coding
  - Improved Reimbursement
  - Clarification of Present on Admission (POA) indicators and Hospital Acquired Conditions
- Retrospective reviews of inpatient records for conflicting, incomplete, or nonspecific provider documentation.

Monitoring the Program

Performance Measures

Reporting Metrics

- DRG Focus Areas
  - DRGs with or without a CC/MCC
  - Current Focus DRGs
    - Sepsis
    - Chest Pain
    - Symptom code as Principal Diagnosis
    - Acute Renal Failure versus Dehydration
    - Congestive Heart Failure
- Case Mix Index
  - Higher CMI – higher complexity/severity of patients

Monitoring the Program

Performance Measures

Reporting Metrics

- DRG Error Rate
- Percent of Coding Errors
- Coding errors due to physician documentation
- Sequencing of diagnoses and procedures
- Incorrect Discharge Disposition
- Analyze and Trend Queries
  - Provide education based on trends
    - Sepsis, Altered Mental Status, Anemia due to blood loss

Documentation Improvement

Benefits/Outcomes

- Improved final DRG assignment
- Reduce coding turn-around-time
- Accurately reflect the severity of illness for patient population
- Improve CC/MCC capture rate
- Decrease post-discharge queries
- Validated admission orders
  - (i.e. admission versus observation)

Monitoring the Program

Regardless of which model is chosen and whether CDI staff are nurses or coders

- Coding training will be necessary
- Better communication skills
- Re-review of anatomy and physiology, medical terminology, pathology
- Develop Query database
  - Capture DRG variance – Original DRG versus Final
- Denial Management Initiative
  - Reduce number of denied accounts
  - Understand reason for denials
  - Develop denial/appeal strategies to get bills paid

Monitoring the Program

- Physician Education
  - One-on-One or Group
- Promote the program
  - Ask for inclusion in medical staff morning or afternoon meetings
- Develop documentation tips by department
- Create newsletter
- Physician Documentation Report Card
  - Provide incentives for best results
    - Example: Lunch

Monitoring Performance

Continuous performance tracking and monitoring is essential to measure program's success

- Measure successes
- Identify any barriers
- Measure the productivity and quality of the CDI Team members
- Identify training opportunities
- Reward Staff

Summary

Why is clinical Documentation Important?

- Improved quality of care
- Correct, complete, accurate documentation impacts patients, physicians and MTFs
- All clinicians are responsible for documenting the treatment and outcomes of the patient
- Documentation is used for clinical research and education
- Supports diagnoses and procedures that were billed
- Impacts reimbursement
- Compliance with CMS regulations

Summary

A successful clinical documentation program leads to

- Better communication with providers
- Decreased retrospective queries
- Increase in reimbursement
- Minimize denied accounts
- But most of all – improved clinical documentation!

Summary

Revenue is Revenue

But

Clinical Documentation is Important

Questions?

Resources

- The Clinical Documentation Improvement Specialist's Handbook, Marion Kruse/Heather Taillon, 2011
- Documentation Strategies to Support Severity of Illness, Robert Gold, MD, 2005
- Guidelines for Medical Record and Clinical Documentation, WHO-SEARO coding workshop, 09/07
- Medicare Conditions of Participation for Hospitals, www.cms.gov
- State Operations Manual, Appendix A, Survey Protocol, www.cms.gov/manuals/downloads/som107ap_a_hospitals.pdf
- Concepts of Coding CDI Programs, AHIMA Audio Seminar, 01/08
- Clinical Documentation Improvement Toolkit, AHIMA, 2010
- Federal Register, Vol. 75, No. 157, 08/10
- Eliminating Waste and Fraud in Medicare and Medicaid, Deborah Taylor, 04/22/09, www.hhs.gov/asl/testify/2009/04/t20090422.html
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Background Slides